# SUMMIT MEDICAL GROUP PATIENT REGISTRATION FORM

| ACCOUNT # | DATE | PHYSICIANS NAME |
|---|---|---|

| PATIENT'S FIRST NAME | MIDDLE NAME | LAST | BIRTHDATE | AGE |
|---|---|---|---|---|
| | | | | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| SOCIAL SECURITY # | HOME PHONE # | MOBILE PHONE # | WORK OR BUSINESS PHONE # | MARITAL STATUS | SEX |
|---|---|---|---|---|---|
| | | | | | |

| EMPLOYER'S NAME AND ADDRESS | RACE | |
|---|---|---|
| | | ☐ 01 AFRICAN AMERICAN ☐ 08 NATIVE AMERICAN |
| | | ☐ 02 ASIAN ☐ 11 OTHER _____ |
| | | ☐ 03 CAUCASIAN |
| | | ☐ 06 HISPANIC |

| EMAIL ADDRESS | PRIMARY LANGUAGE: |
|---|---|
| | |

| PHARMACY OF CHOICE | PHARMACY PHONE # |
|---|---|
| | |

HOW WERE YOU REFERRED TO SUMMIT MEDICAL GROUP ?

| HAVE YOU BEEN TREATED BY A SUMMIT MEDICAL GROUP PHYSICIAN PREVIOUSLY ? ☐ YES ☐ NO | DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE ? ☐ YES ☐ NO<br>DO YOU HAVE A LIVING WILL ? ☐ YES ☐ NO<br>**If yes, Please provide a copy of the above document(s) to the office for your medical record.** |
|---|---|

## PERSON/GUARANTOR RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT FROM PATIENT)

| FIRST NAME | MIDDLE NAME | LAST | RELATIONSHIP TO PATIENT |
|---|---|---|---|
| | | | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| SOCIAL SECURITY # | HOME PHONE # | MOBILE PHONE # | WORK OR BUSINESS PHONE # | BIRTHDATE | SEX |
|---|---|---|---|---|---|
| | | | | | |

EMPLOYER'S NAME AND ADDRESS

## EMERGENCY CONTACT (NOT WITHIN THE SAME HOUSEHOLD)

| NAME | EMERGENCY PHONE NUMBER | RELATIONSHIP TO PATIENT |
|---|---|---|
| | | |

## INSURANCE INFORMATION

| PRIMARY INSURANCE | | SECONDARY INSURANCE | |
|---|---|---|---|
| INSURANCE NAME | EFFECTIVE DATE | INSURANCE NAME | EFFECTIVE DATE |
| | | | |
| CLAIMS ADDRESS | | CLAIMS ADDRESS | |
| | | | |
| SUBSCRIBER ID NUMBER | GROUP NUMBER | SUBSCRIBER ID NUMBER | GROUP NUMBER |
| | | | |
| SUBSCRIBER NAME AND ADDRESS | | SUBSCRIBER NAME AND ADDRESS | |
| | | | |
| SUBSCRIBER BIRTHDATE | | SUBSCRIBER BIRTHDATE | |
| | | | |
| SUBSCRIBER SS# | RELATION TO PATIENT | SUBSCRIBER SS# | RELATION TO PATIENT |
| | | | |
| EMPLOYER NAME, ADDRESS AND PHONE NUMBER | | EMPLOYER NAME, ADDRESS AND PHONE NUMBER | |
| | | | |

FOR PRESCRIPTIONS, DO YOU USE YOUR ☐ PRIMARY INSURANCE ☐ SECONDARY INSURANCE ☐ OTHER _____

The Patient or Guarantor is responsible for payment in full of all services rendered by the physicians or employees of Summit Medical Group, PLLC. Payment in full is expected at the time of service unless arrangements are made in advance.

**AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT**

I hereby authorize Summit Medical Group, PLLC to release to the above insurance companies &/or carriers any medical or other information needed for claims reimbursement. I hereby assign, transfer, and set over to Summit Medical Group, PLLC all of my rights, title, and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by Summit Medical Group, PLLC.

_____ _____

DATE SIGNATURE OF PATIENT/GUARDIAN

# PATIENT CONSENT FOR MEDICAL TREATMENT

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Summit Medical Group, through its individual physicians, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician and provided by Summit Medical Group.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or Summit Medical Group.

I acknowledge that I have received a copy of Summit Medical Group's Notice of Privacy Practices and I understand that the notice is also posted at each location where services are provided and on the internet at www.summitmedical.com. I consent to be called on my cell phone concerning healthcare services rendered to me.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient of Summit Medical Group. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my physician and that the results of all tests will be kept confidential.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

_____ _____

Patient's Signature Patient's Name (Printed)

_____ _____

Witness Date

Patient, _____, is a minor, or is unable to sign above because: _____.
(Name Printed)

_____ _____

Person Giving Consent Relation to Patient

_____ _____

Witness Date